

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

-63-007532

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

Registration District No. 387

Primary Registration District No. 3099

Registrar's No. 312

STATE FILE NUMBER

DO NOT WRITE
ON THIS SUB

AMENDED

VS 300
Rev. 4/59b585
2585

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DATE/AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF DEATH a. COUNTY <u>Linn</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>Linn</u>	
b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN <u>Brookfield</u>		c. CITY OR TOWN <u>Brookfield</u>	
Length of stay in 1b <u>10 days</u>		Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION <u>Pershing Memorial Hosp.</u>		d. STREET ADDRESS (If outside, give location) <u>137 East Robard</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Thelma Jane McKenzie</u>		4. DATE OF DEATH Month Day Year <u>February 8, 1963</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. Married <input type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH <u>6/3/1900</u>
9. AGE (last birthday) <u>62 yrs.</u>		IF UNDER 1 YEAR IF UNDER 24 HR Months Days Hours Min. <u>8 5</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife and cook</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Restaurant</u>	
11. BIRTHPLACE (City and state or country) <u>Bevier, Mo.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.</u>	
13a. FATHER'S NAME <u>James Howard Walden</u>		13b. MOTHER'S MAIDEN NAME <u>Ada Belle Skinner</u>	
14. NAME OF HUSBAND OR WIFE <u>Ray McKenzie</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of)	
16. SOCIAL SECURITY NO. <u>72</u>		17. INFORMANT Address <u>Mrs. Dorothy Hayen, Brookfield, Mo.</u>	
18. CAUSE OF DEATH (Enter only one cause per PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u> Conditions, if any, which gave rise to above cause (a), stating the underlying cause last. DUE TO (b) <u>Arteriosclerosis, and anemia, in aorta</u> DUE TO (c) <u>Carcinoma of breast metastatic to heart</u>		INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> <u>30 days</u> <u>18 mos</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)		PART III. If deceased was female, was there a pregnancy in last 90 days <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)	20f. CITY, TOWN, OR LOCATION COUNTY STATE		
21. I attended the deceased from <u>11-15-62</u> to <u>2-8-63</u> and last saw her alive on <u>2-8-63</u> Death occurred at <u>3:45 P.m.</u> on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE <u>E. E. Smock DO</u> (Degree or title)		22b. ADDRESS <u>Brookfield Mo</u>	
22c. DATE SIGNED <u>2-10-63</u>		23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	
23b. DATE <u>Feb. 10, 1963</u>		23c. NAME OF CEMETERY OR CREMATORY <u>New Cambria Cemetery</u>	
23d. LOCATION (City, town, or county) <u>New Cambria, Mo.</u>		23e. STATE <u>Mo.</u>	
24. FUNERAL DIRECTOR <u>H. E. Hilliland</u>		25. DATE RECD. BY LOCAL REG. <u>2/10/63</u>	
26. REGISTRAR'S SIGNATURE <u>Anna Watson</u>		27. (Licensed Embalmer's Statement on Reverse Side)	

USE BLACK INK
OR
TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by _____ Student Embalmer No. _____

working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

H. J. Gilleland

Licensed Embalmer No. *4019*

P. O. Address *Marlambria Mo*

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.